EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Isabella Riedy

Final Grade: Satisfactory

Semester: Fall

Date of Completion: 12/2/2024

Faculty eSignature: Heather Schwerer MSN, RN

Faculty: **Frances Brennan**, MSN, RN; **Amy Rockwell**, MSN, RN;
Chandra Barnes, MSN, RN; **Nick Simonovich,** MSN, RN
Heather Schwerer, MSN, RN; **Brittany Lombardi,** MSN, RN, CNE

Teaching Assistant: Stacia Atkins, BSN, RN

DIRECTIONS FOR USE:

Each week the students evaluate themselves based on the competencies using the performance code on page 2. The performance code includes the terms **Satisfactory (S), Needs Improvement (NI), Unsatisfactory (U), and Not Available (NA).** The faculty member will initial if in agreement with the student's evaluation. If there is a discrepancy in the performance code evaluation between the student and the faculty member, a note is written in the comment section by the faculty member with the rationale for the evaluation. All competencies must be rated a "S, NI, U, or NA". If the student does not self-rate, then it is an automatic "U". A student who submits the clinical evaluation tool late will be rated as "U" in the appropriate competency(s) for that clinical week. Whenever a student receives a "U" in a competency, it must be addressed with a comment as to why it is no longer a "U" the following week. If the student does not state why the "U" is corrected, it will be another "U" until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. **An unsatisfactory or needs improvement as a final evaluation in any single competency results in a clinical course grade of unsatisfactory; this is a failure of the course. Patterns of performance over the course of the semester will be utilized to determine the final competency evaluations. The terms Satisfactory and Unsatisfactory will be used in evaluating the final grade or clinical course performance.**

METHODS OF EVALUATION:

Skills Lab Checklists
Care Map Grading Rubric
Administration of Medications
Simulation Scenarios
Skills Demonstration
Evaluation of Clinical Performance Tool
Clinical Discussion Group Grading Rubric
Lasater Clinical Judgment Rubric
Faculty Feedback
Documentation
Clinical Reflection

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)
10/13/2024	5 hours	Unprepared for clinical	10/21/2024-0700-1200
10/15/2024	2 hours	CDG-late	10/15/2024- 2 hr

Faculty's Name	Initials
Chandra Barnes	CB
Frances Brennan	FB
Amy Rockwell	AR
Nicholas Simonovich	NS
Heather Schwerer	HS
Brittany Lombardi	BL

Stacia Atkins	SA

PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

Satisfactory (S): Safe, accurate each time, efficient, coordinated, confident, focuses on the patient, some expenditure of excess energy, within a reasonable time period, appropriate affective behavior, occasional supporting cues, minimal faculty feedback needed related to written clinical work.

UNSATISFACTORY CLINICAL PERFORMANCE

Needs Improvement (NI): Safe, accurate each time, skillful in parts of behavior, focuses more on the skill and self rather than the patient, inefficient, uncoordinated, anxious, worried, and flustered at times, expends excess energy within a delayed time period, frequent verbal and occasional physical directive cues in addition to supportive cues, faculty feedback required in several areas of clinical written work.

Unsatisfactory (U): Failure to achieve the course competency, safe but needs faculty reminders constantly, not always accurate, unskilled, inefficient, considerable expenditure of excess energy, anxious, disruptive or omitting behaviors, focus on skills and/or self, continuous verbal and frequent physical cues, unsafe, performs at risk to patient/clients/others, unable to function, incomplete, erroneous, faulty, illegible clinical written work, no feedback sought from faculty or response to feedback not evident in submitted written work. If the student does not self-rate a competency the competency is graded "U." A "U" in a competency must be addressed in writing by the student in the Evaluation of Clinical Performance tool. The student response must include how the competency has been or will be met at a satisfactory level. If the student does not address the "U", the faculty member (s) will continue to rate the competency unsatisfactory.

OTHER

Not Available (NA): The clinical experience which would meet the competency was not available.

***Grey shaded weekly competency boxes do not need a student evaluation rating or faculty/teaching assistant initials.**

Objective

1. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. (2,4,6)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies: a. Identify spiritual needs of patient (Noticing).									NA	S	NA	S	NA	S	S	S
b. Identify cultural factors that influence healthcare (Noticing).									NA	S	NA	S	NA	S	S	S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	S
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).						NA	S	NA	S	S	NA	S	NA	S	S	S
						CB	CB	CB	CB	HS	HS	HS	HS	HS	FB	HS
Clinical Location; Patient age**						NA	3T 88	NA	NA	3T 70	NA	3T 79	NA	3T 62	3T 66	

Comments

****Document your clinical location and patient age in the designated box above.**

Week 7(1c,d): Great job showing respect for your patient's needs, being compassionate and kind while delivering care. You also demonstrated the appropriate use of Maslow's hierarchy of needs during the head to toe assessment performed on your patient during this clinical experience, being able to recognize physiological needs of your patient when performing head to toe assessment. CB

Week 9(1c,d)- Your patient had an extended stay at the hospital, and you did a nice job providing her care based on her needs and preferences. You also utilized Maslow's Hierarchy of needs to determine the care needed. Nice job! HS

Week 11(1a,c,d) You spent a lot of time listening to your patient which was very important for him. You were able to incorporate his preferences and needs into the plan of care. You allowed him to have a say in the way that the care was provided while also educating him on the why certain interventions were being performed. HS

Week 13 (1c,d) Nice job considering your patient's preferences while coordinating appropriate care to ensure positive patient outcomes. You did a nice job allowing your patient a say in the timing of his care being provided. HS

Week 14/makeup (1c)- Great job respecting the preferences for your assigned patient during this clinical experience. You were very respectful as you were implementing the plan of care for a difficult patient. FB

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective

1. Summarize knowledge of anatomy, physiology, chemistry, nutrition, psychosocial and developmental principles in performance of basic physical assessment through use of clinical judgment skills. (3,4, 5)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies: a. Perform head to toe assessment utilizing techniques of inspection, palpation and auscultation (Responding).						NA	NI	NA	NI	S	NA	S	NA	S	S	**S**
b. Use correct technique for vital sign measurement (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).						NA	~~S~~ NA	NA	NA	S	NA	S	NA	S	S	**S**
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).									NA	~~NA~~ S	NA	S	NA	S	S	**S**
e. Collect the nutritional data of assigned patient (Noticing).									NA	S	NA	S	NA	S	S	**S**
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).									NA	NA	NA	NA	NA	NA	NA	**NA**
g. Describe the findings and the rationale for diagnostic studies with the nursing implications for assigned patient (Interpreting).									NA	S	NA	S	NA	S	S	**S**
						CB	CB	**CB**	CB	HS	HS	HS	HS	HS	FB	**HS**

Comments

Week 7: I put "Needs Improvement" for 2.a. because I forgot to assess the capillary refill of all four extremities during my head-to-toe assessment. Thank you for explaining why you rated yourself this way. The more clinical experience you get, the easier it will be to remember all components of a head-to-toe assessment. CB

Week 7(2a,b): Izzy, you performed a systematic head to toe assessment and retrieved all vital signs within a timely manner. Competency 2c was changed to a "NA" due to not conducting a fall assessment this clinical. CB

Week 9(2a-d) You did a nice job this week completing your vital signs, head to toe assessment, fall/safety, and skin assessment. You were able to identify abnormal lungs sounds of rhonchi while auscultating your patients' lungs. You also identified that the patient had been refusing the bed alarm and provided education and maintained fall precautions during your shift. You also did an excellent job on your pain assessment and made sure to document it thoroughly. HS

Week 11(2a-d) You did a great job with your assessment this week. Your patient had a lot of abnormal assessment findings and you were able to identify them. You did a nice job completing his fall/safety and skin assessment and implementing the appropriate interventions for the plan of care based on your findings. HS

Week 13 (2a,c,d)- You did a great job performing appropriate assessments. You were able to identify that you need to use the doppler to obtain pedal pulses and you were also able to assess his lower leg edema and the severity of it. You provided pertinent information from assessments, labs, and diagnostic testing to determine a priority problem for your assigned patient. Associated interventions were implemented that were relevant to the priority problem based off of information gathered.
(2g) Great job interpreting the lab data and diagnostic procedures that provides substantial information for the priority problem. HS

Week 14/makeup (2a,b,e)- Great job with head to toe and focused assessments. You implemented the correct technique for a manual blood pressure when the automatic blood pressure machine did not complete appropriately. You also encouraged the patient to intake nutritious food for optimal health outcomes. FB

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective																
2. Select communication techniques and appropriate boundaries with patients, families, and health care team members. (1,2,3,4,6,7)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Receive report at beginning of shift from assigned nurse (Noticing).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
b. Hand off (report) pertinent, current information to the next provider of care (Responding).						NA	NA	NA	NA	S	NA	S	NA	S	S	**S**
c. Use appropriate medical terminology in verbal and written communication (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
d. Report promptly and accurately any change in the status of the patient (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
e. Communicate effectively with patients and families (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	S
f. Participate as an accountable health care team member in the provision of patient centered care (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	S
						CB	CB	**CB**	CB	HS	HS	HS	HS	HS	FB	HS

Comments

Week 7(3a,c,d,e): Great job receiving hand off report on your patient. Good job using medical terminology while communicating with your patient, reporting abnormal findings, and communicating effectively with your staff RN. CB

Week 9 (3a-f) You did a nice job receiving report from the previous shift and updating the nurse at the end of your shift. You notified the nurse regarding your patient being in pain, and you informed her of all of the associated information and documented accordingly. HS

Week 11(3a-f) You were able to receive a report from the nurse at the beginning of the shift. You communicated with her throughout the shift informing her of any concerns you had, such as the patient not wearing his SCD's and the stat lock not fitting the Foley correctly. You were able to discuss the plan of care for the patient. You also used appropriate medical terminology with the patient when speaking to him about his edema. You asked him if he understood what it meant, and he did and then you explained what he could do to help decrease it. Great job! HS

Week 13 (3a,b) Good job this week receiving report from the off going shift and giving appropriate information to the bedside nurse when leaving clinical for the day. (3e) Nice job communicating with your patient as he became grumpy at times during the clinical day, you were able to explain what needed to be done and then he agreed to cooperate with you. HS

Week 14/makeup (3e,f)- Great job communicating with the patient and educating the patient on their plan of care. You demonstrated accountability in implementing the appropriate interventions to foster positive patient outcomes, including fall precautions, nutrition, and self-care. FB

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective																
3. Exemplify advanced searches in accessing electronic health care information and documenting patient care. (1,4,8)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Document vital signs and head to toe assessment according to policy (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
b. Document the patient response to nursing care provided (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
c. Access medical information of assigned patient in Electronic Medical Record (Responding).		S				NA	S	NA	S	S	NA	S	NA	S	S	**S**
d. Demonstrate beginning skill in accessing patient education material on intranet (Responding).		S							S	NA	NA	NA	NA	S	S	**S**
e. Provide basic patient education with accurate electronic documentation (Responding).									NA	NA	NA	S	NA	S	S	**S**
f. Consistently and appropriately post comments for clinical discussion groups on Edvance360 website (Reflection).						NA	S	NA	S	S	NA	S	NA	~~S~~ U	NA	**S**
*Week 2 –Meditech		CB				CB	CB	**CB**	CB	HS	HS	HS	HS	HS	FB	**HS**

Comments

Week 2(4c,d): Satisfactory for listening attentively and actively participating in the Meditech orientation clinical. You showed beginning competence in the ability to access a patient's EHR, document care in an intervention, and locate patient data. You were able to access Lexicomp to locate patient education materials. Additionally, nursing policies and procedures were located on the health system intranet. Great job! NS/CB

Week 7(4a,b,c,f): Satisfactory job with documentation of the head to toe assessment and vital signs of your patient. Make sure to note any areas you may have forgot to assess, so that assessments and documentation are thorough and accurate. You did a good job utilizing Meditech for documentation and to look up patient information. You completed your first cdg, meeting all requirements per the grading rubric, excellent job! CB

Week 9(4a,b,c) You did a good just this week documenting all of the care and interventions you provided to your patient.
(4f)- Nice job on your initial CDG post and the peer response you met all of the rubric requirements and provided a thorough response to your peer. HS

Week 11(4a,b,c) Great job this week with your assessment this week! Your patient had a lot of abnormal assessment findings and you took your time in order to complete a thorough assessment. You identified his lower leg edema and that he was not wearing his SCD's, and that he did not have his Foley catheter secured. After identifying these concerns, you implemented the appropriate interventions. Great job! HS
(4f) Nice job on your initial CDG post and the peer response you met all of the rubric requirements and provided a thorough response to your peer. HS

Week 13 (4 a,b,c) Great job with head to toe assessment, vital signs, and focused assessment. You documented thoroughly and in a timely manner. Nice job accessing pertinent information and additional information within the electronic medical record. You were able to identify and gather important information regarding your patient's problems and testing to provide an accurate plan of care, nice job!
(4f) This competency was changed to an **unsatisfactory** evaluation because you submitted your initial CDG post late.
Whenever a student receives a "U" in a competency, it must be addressed with a comment as to why it is no longer a "U" the following week. If the student does not state why the "U" is corrected, it will be another "U" until the student addresses it. HS
I received a "U" on week 13 (4f) because my initial CDG post was submitted at 2230 when it was due at 2200, making it 30 minutes late. In the future I will make sure that I give myself enough time to complete the CDG's along with ensuring that my computer is working properly. I will do this by completing my CDG a day before it is due to give myself enough time when typing out my response and submitting it through the computer. I will make sure to write down when the CDG's are due on a sticky note and tape it to my computer to ensure that I will not mess up any times and dates up when turning in assignments. Great idea, it might also be beneficial to set up a reminder on your phone. FB

Week 14/makeup (4 a,b)- Great job with documentation this week with minimal editing needed. Documentation was thorough and accurate. (4c)- You were able to access the medical record, gather pertinent information and interpret data for your assigned patient. FB

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective																
4. Exemplify psychomotor skills and nursing care safely using evidence-based practice. (3,4,5,7,8)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Demonstrate correct body mechanics and practices safety measures during the provision of patient care (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
b. Apply the principles of asepsis and standard/infection control precautions (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
c. Demonstrates appropriate skill with foley catheter insertion, maintenance, and removal (Responding).									NA	NA	NA	S	NA	S	NA	**S**
d. Manage basic patient care situations with evidence of preparation and beginning dexterity (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
e. Organize time providing patient care efficiently and safely (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
f. Manages hygiene needs of assigned patient (Responding).									NA	S	NA	S	NA	S	S	**S**
g. Demonstrate appropriate skill with wound care (Responding).									NA		NA	NA	NA	NA	NA	**NA**
h. Document the location of fire pull stations and fire extinguishers. ** (Interpreting).						NA	S	NA	S							**S**
						CB	CB	CB	CB	HS	HS	HS	HS	HS	FB	**HS**

Comments

****You must document the location of the pull station and extinguisher here for your first clinical experience.**

One pull station on 3T is located at the front desk and a fire extinguisher is located by room 3010 by the stairs. Great job! CB

Week 7(5a,b): Great job utilizing correct body mechanics and raising the bed while performing an assessment. You did a great job ensuring that you foamed in/out when entering/exiting patients' rooms. CB
Week 9(5d,e,f)- You did a nice job going right in the patients room and getting your assessment completed and assisting the patient with her meal tray and hygiene care. You planned your time efficiently in order to complete all tasks. You did all of these tasks in a timely manner and maintained safety and encouraged independence from the patient. HS

Week 11(5d,e,f) You did a nice job completing the necessary interventions and care for your patient. He had a lot going on and you were able to prioritize and organize the care effectively. You also did a nice job encouraging hygiene care even though he was not in favor of it, you managed to ensure that the Foley care was completed. HS

Week 13 (5 d,e,f)-You have demonstrated great management of care for your assigned patient making sure all pertinent interventions were completed. You organize your time appropriately to provide safe, efficient care to ensure positive patient outcomes. Great job with time management this week with your medication administration. You had a very busy clinical day. HS

Week 14/makeup- (5 d,e)- You have demonstrated great management of care for your assigned patient making sure all pertinent interventions were completed. You organize your time appropriately to provide safe, efficient care to ensure positive patient outcomes. (5f)-You encouraged and educated on hygiene care for your patient. FB

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective																
5. Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Utilize clinical judgment skills to develop a patient-centered plan of care (Responding).									NA	S	NA	S	NA	S	S	**S**
									CB	HS	HS	HS	HS	HS	FB	**HS**

Comments

Week 9 (6a)- You did a nice job utilizing clinical judgement skills based on your patient's priority problem and then identifying interventions specific to the patient and developing the plan of care. HS

Week 11(6a) Excellent job utilizing your clinical judgment skills to care for your patient this week. You assured the plan of care fit your patient's needs and preferences. You will continue to grow these skills as you progress through the semester and program. HS

Week 13 (6a)- Good job this week assessing your patient and gathering information from the electronic medical record to help you identify your patient's priority problem, and centering patient care around that. HS

Week 14/makeup (6a)- Great job utilizing clinical judgement while providing care to your patient during this clinical rotation. FB
Week 14 (6a)- Great job on your care map! You were able to identify a priority problem based on your abnormal assessment findings, lab values, and risk factors. You then successfully identified the plan on care and determined interventions specific to the patient. HS

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective																
6. Convert basic pharmacology principles into safe medication administration. (3,5,6,7)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Identify the action, rationale, dosage, side effects and the nursing implications of medications (Interpreting).									NA				NA	S	S	**S**
b. Recognize patient drug allergies (Interpreting).									NA				NA	S	S	**S**
c. Practice the 6 rights and 3 checks prior to medication administration (Responding).									NA				NA	S	S	**S**
d. Administer oral, intra-muscular, subcutaneous, and intradermal medications using correct techniques (Responding).									NA				NA	S	S	**S**
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).									NA				NA	NA	NA	**NA**
f. Assess the patient response to PRN medications (Responding).									NA				NA	NA	NA	**NA**
g. Demonstrate medication administration documentation appropriately using BMV (Responding).									NA			S	NA	S	S	**S**
*Week 11: BMV									CB			HS	HS	HS	FB	**HS**

Comments

Week 11 (7g) - You are satisfactory for this competency by attending the Bedside Medication Verification (BMV) clinical orientation, actively listening, observing, and discussing accurate medication documentation and safe administration with the use of the BMV scanner. NS/CB

Week 13 (7a-d, g)- Great job with medication administration (oral and topical)! You were able to identify why your patient was receiving the medication, potential side effects, and appropriate patient education. You reassessed your patient after giving medications, ensuring their safety. You followed the 7 rights of medication administration with 3 medication checks, verifying the correct patient and their allergies. You were able to utilize the BMV for medication administration documentation. HS

Week 14: I had the opportunity to administer a flu vaccine to a patient. Great job!

Week 14/makeup (7c,d)-You demonstrated the use of the seven rights of medication administration and used the correct technique when you administered an IM vaccine to a patient. (7g) You demonstrated appropriate use of the barcode medication verification system for patient identification and administration of medications was saved. Keep up the great work! FB

* End-of-Program Student Learning Outcomes

Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective																
2. Exemplify professional conduct through self-reflection, responsibility for learning, and goal setting. (1,5,7)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: **a. Reflect on areas of strength****(Reflecting)						NA	S	NA	S	S	NA	S	NA	S	S	**S**
b. **Reflect on areas for self-growth with a plan for improvement. **** (Reflecting)						NA	S	NA	S	S	NA	~~S~~ NI	NA	S	S	**S**
c. Incorporate instructor feedback for improvement and growth (Reflecting).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
d. Follow the standards outlined in the FRMCSN policy, "Student Code of Conduct" (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).						NA	S	NA	S	S	NA	S	NA	~~S~~ U	S	**S**
g. Comply with patient's Bill of Rights (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
h. Respect the privacy of patient health and medical information as required by federal HIPAA regulations (Responding).						NA	S	NA	S	S	NA	S	NA	S	S	**S**
i. Actively engage in self-reflection. (Reflecting)						NA	S	NA	S	S	NA	S	NA	S	S	**S**
*						CB	CB	**CB**	CB	HS	HS	HS	HS	HS	FB	**~~HS~~**

**** Strength/weakness reflection (a,b): Must have different written example each week of clinical/lab. You must explain your plan for how you will improve. Example, "I am having a difficult time with obtaining a manual BP. I will get a BP cuff from Amy and practice manual BP's with at least three members of my family this week." Please ensure that you answer this section in-depth with your plan of action. Each week must be different.**

Week 7:

a. My area of strength was staying calm and collected while ensuring good communication with my patient. I hope to continue good communication with my patients and staying calm even if I am overwhelmed. Good communication is key in providing patient centered care, great job! CB
b. My area of weakness was not keeping up during the hand-off report of my patient. Next time I will be sure to know beforehand how the sheet is set up and will keep up when information is given to me, not missing any details. Looking over the hand-off report sheet is a good plan to ensure that you know where to put patient information. CB

Week 7(8d,f,h): Excellent job following the student code of conduct, exhibiting professionalism while in the clinical setting, and ensuring that patient privacy was respected. CB

Week 9:

a. My area of strength was utilizing different approaches to encourage my patient to get up to the chair for meals. Within the charting system I was able to see that my patient had been continuously refusing to get up to the chair at all during the day. The goal was to at least get up to the chair to eat meals, this would also help relieve some of the symptoms they were experiencing. They started off the morning by refusing right away, I continued to educate and pursue my patient each time I went in the room about the benefits of sitting in the chair for even if it was just a short thirty minutes. Once we started the hygiene care I was able to get them to the chair and they ended up feeling much better than before and ended up staying for a couple hours. This was the first time they had been out of the bed in days. Their symptoms were relieved greatly. I hope to be able to continue using different communication tactics to positively impact my patients. Using education, encouragement, and positivity. Great job! HS
b. My area of weakness was making the time to utilize skyscape. It was harder than I thought to find an open computer or space that I would've been able to utilize using skyscape, along with knowing I had a good amount of time to do so. I was able to finish my assessments and other interventions in a timely manner, however there were other factors like my patient meal tray getting lost and having to reorder, that took up the extra time that I would've had. All my charting was done in the room, I made sure to take some notes on diagnoses that I wanted to look up on skyscape for my CDG. Next time I hope I can have the opportunity to have a little extra time to utilize skyscape. I think once I get use to the interventions and charting that I need to complete each clinical, it will make it easier to squeeze in time for these things. I hope to continue to improve my time management by being more aware and efficient when completing each intervention. Each clinical experience will be different and some days you will have extra time and other days you may not have enough time. Becoming more comfortable and familiar with the documentation will allow for additional time in other areas. HS

Week 11:

a. This week my area of strength was utilizing skyscape. Last clinical it was hard for me to manage my time, making it hard to use skyscape. This made it difficult to understand and gather all the information regarding my patient. I included that within my area of weakness within the last clinical evaluation. This week I made sure to take time to utilize skyscape by researching my patient's history, diagnoses, and priority problems. I was able to learn extensive knowledge on diagnoses that connected the dots with what was going on with my patient. With each clinical it has become easier to manage my time when completing my assessments and obtaining information regarding my patient. I hope to continue managing my time efficiently especially during the busier clinical days. Making sure to utilize skyscape to see my all of my patients' problems as a whole and what details contribute to each other. HS
b. This week my area of weakness was finding the appropriate way to communicate with my patient. My patient this week was depressed from being in the hospital setting for a long period of time, struggling with chronic illnesses. My patient expressed wanting to pass away, missing family/support system, losing loved ones, and having a hard time trusting the hospital staff. I made sure to take the time to sit and talk with my patient, providing any comfort they may have needed. Education, clearing up any confusion, and providing support. I struggled finding what to say when my patient brought up wanting to pass away and how messy their family life may be. I tried to provide support and uplifting communication, but it put me at a pause on how to respond. I did not know what to say regarding these specific topics. I asked if they could explain their feelings to me, provided my time and support, however I am not still sure on how to handle these types of situations. I hope to learn more on how to support these patients, and what I can say and do to make a positive impact. This is a difficult situation that you will encounter many times during your clinicals and nursing career. I changed this competency to a NI because you did not specifically state how you plan to improve upon this weakness. In the future you must list a plan on how you will improve. HS

Week 13:

a. This week my area of strength was using my time wisely. I had to do medication administration this day of clinical and while that took up a good amount of time, researching each medication and becoming knowledgeable on them along with administering them. I still make sure to sit with my patient and plan their care for the day. Making sure to fit in all hygiene, change sheets, gown, assessments, interventions, foley care, communication with the nurse, and set up safety precautions because they were a high fall risk, and nothing was in place for that. Along with making sure to access Meditech to learn more about my patient and sit with them to get to know them and their situation. I hope to continue prioritizing my interventions and assessments according to the time that I am given. Even though it gets extremely stressful and down to the last minute I will make sure to fit in as much as possible including hygiene, education, and good one on one communication. I plan to do this by monitoring my time throughout the day to make sure I have the time to fit in each intervention and mandatory assessment. I typically do this by using my watch, making sure I am aware of the pace I am going at and how much time I am taking to complete my tasks efficiently. The day can become very busy depending on the needs of the patient. You did a nice job prioritizing care and interventions. HS

b. This week I had two areas of weaknesses. My first area of weakness was being unprepared. I forgot my stethoscope on the first day of clinical this week which is a required piece of my uniform. To prevent this from happening again I will make sure to take the time to efficiently go through my bag to make sure I have everything I need for clinical. Along with accessing the sheet of requirements needed for clinical so I can use that list to make sure I have everything prepared the night before. My other area of weakness this week was medication administration. When accessing skyscape to research each medication and knowing the indication specific for my patient I struggled finding all the information that I needed. I also had a hard time writing down all the medication information on my sheet of paper. I hope to become more confident and efficient with medication administration and pronouncing the names. To improve on this, I am going to make a sheet that works better for me when writing down the information. I will also practice researching medications on skyscape and knowing where each piece of information is located. Medication preparation and administration was overwhelming for me so I will also make sure to take a deep breath before starting to ensure clear thinking. Medications can be very challenging however, it will get a little easier with each experience of administration. HS

Week 13 (8f)- This competency was changed to an unsatisfactory because of being unprepared for clinical on Wednesday and the late CDG submission on Friday. Whenever a student receives a "U" in a competency, it must be addressed with a comment as to why it is no longer a "U" the following week. If the student does not state why the "U" is corrected, it will be another "U" until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. HS

I received a "U" on week 13 (8f) because I was unprepared for clinical on Wednesday November 13th. I forgot my stethoscope which is a required piece of the uniform for clinical. In the future I will be sure to bring every required piece of my uniform to clinical. I will do this by printing out the handbook and other sheets of paper that include what is needed for each clinical. I will make sure to prepare everything utilizing the lists the night before to ensure everything is ready for the next morning. Before leaving for the clinical in the morning I will make sure again that I have everything listed packed in my clinical bag to ensure I am prepared once I arrive at the hospital. Great idea, it is beneficial to prepare ahead of time, so that you are not rushed and you are well prepared. Thank you for being honest and taking accountability for your actions. This says a lot about your character! FB

Week 14/makeup:

a. This week my area of strength was using different approaches when communicating with my patient. When I received the hand off report the nurse said that my patient is "confused" at times. My patient had said different dates for last bowel movement along with coming across as hard to read when performing the pain assessment. When I performed a mental status assessment on my patient, they were oriented x4 along with memory being intact. It seemed as if they were trying to stay in the hospital as long as possible. They would be laying in bed having a conversation with me and when I asked the pain assessment they would then bend over and moan in pain. Stating that they are in ten out of ten abdominal pain that is sharp and cramping. This happened almost every time I went into the room and asked how they were doing and if they were in any pain. When talking to them about their bowel movements and pain I made sure to ask several times and tried to get as much information as possible to be able to use my clinical judgement. With pain we must believe what the patient is telling us because they are the only ones that can communicate this information. So, I made sure to stick to that mindset and communicate the assessment with the day shift nurse. I used many different approaches when communicating, asking open ended questions and different directed questions to get as much information as I could. I ended up getting the same

response each time regarding their pain and bowel elimination. I think it is also important to consider that every person has a different pain tolerance, a 4/10 pain rating to one person could be an 8/10 rating to another. I hope to continue to use my clinical judgement and the information we have learned in lecture within the clinical setting. I will do this by making sure to communicate with each patient in a way that is most efficient for the situation and continue to communicate appropriately by asking those open-ended questions and digging deep into the situation. Izzy, you did a great job communicating and you are correct sometimes you need to approach the situation in a different manner. Pain is very subjective and every person experiences pain differently. You have developed great clinical judgment skills through the semester and will learn through more experience how to effectively communicate with different personalities. Keep up the great work. FB

b. This week my area of weakness was not being able to get my patient motivated. My patient was refusing everything including a walker, yellow socks, getting up to the chair, eating, drinking, sitting up, opening the blinds, etc. They do have a history of depression, and it is especially hard for these patients when being in the hospital and not having much freedom or their normal routine. My patient had no interest in anything other than lying in the dark and playing on their phone. I did try many times to encourage them to at least sit upright and drink fluids at the bare minimum. However, it unfortunately did not end up making a difference at the time I was present. With previous patients I have been successful by using educational information when promoting their health. For example: sitting up in the chair for meals, putting SCD's on, making sure to utilize the yellow socks, etc. Typically, just taking the time to communicate with a patient makes a world of difference. My patient just wanted to be left alone, there were a couple times where I really encouraged sitting at the edge of the bed, opening the blinds, and taking sips of water. And they did exactly that but when I closed the door and checked in about 3 minutes later, they were back laying down with the covers above their head. I tried to dig into this and see if there was a specific reason that I could help with as to why this was happening, but I did not get a response back. I was hoping that I could've helped the patient in this way by at least getting them to sit up and eat a little something, but it did not end up working out. Next time I hope to utilize different techniques when encouraging a patient in this type of situation to hopefully put a positive change in place that would aid in the overall health of the patient. I will try motivational and educational print off sheets next time. Izzy, you did a great job trying to motivate your assigned patient during this clinical experience. Education is the best tool for patients, it provides the why it is important, the reason behind the plan of care, the rest is up to the patient. The patient really has to want to get better. At times you will exhaust all of your resources and you will not be able to convince the patient that it is in their best interest, but that does not mean that you don't continue to try. FB

Final Comment- Isabella, you did an excellent job this semester! You came to clinical each week ready to learn and gain new experiences. You have grown throughout the semester in your knowledge and skill set. You had challenging patients throughout the semester and provided great care to each one of them while increasing your clinical judgement. You did not get the opportunity to insert, care for, or remove an NG tube, or perform wound care this semester, so please seek out these opportunities in your MSN semester. I look forward to seeing you continue to grow next semester. Great job this semester! HS

* End-of-Program Student Learning Outcomes

Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
11/18/2024	Impaired physical mobility	S/HS	NA

Note: Students are required to submit one satisfactory care map by 11/18/2024 at 0800. If the care map is not evaluated as satisfactory upon initial submission, the student may revise the care map based on instructor feedback/remediation and resubmit one time by 11/25/2024 at 0800 to receive a satisfactory evaluation. ***See Attached Nursing Care Map Grading Rubric**

Firelands Regional Medical Center School of Nursing
Care Map Grading Rubric

Student Name: Isabella Riedy				**Course Objective:** 6			
Date or Clinical Week: 11/18/2024							
Criteria		**3**	**2**	**1**	**0**	**Points Earned**	**Comments**
Noticing	1.Identify all abnormal assessment findings (subjective and objective); include specific patient data.	**(lists at least 7*) *provides explanation if < 7**	**(lists 5-6)**	**(lists 5-7 but no specific patient data included)**	**(lists < 5 or gives no explanation)**	3	You did a nice job providing all of the abnormal assessment findings for your patient (14). You also provided a thorough list of his abnormal lab findings (12) and his chest x-ray. Nice job with the list of risk factors specific to your patient as well. HS
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	**(lists at least 3*) *provides explanation if < 3**		**(lists 3 but no specific patient data included)**	**(lists < 3 or gives no explanation)**	3	
	3. Identify all risk factors relevant to the patient.	**(lists at least 5*) *provides explanation if < 5**	**(lists 4)**	**(lists 3)**	**(lists < 3 or gives no explanation)**	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	You provided a great list of nursing priorities specific to your patient, and included those not only associated with current concerns but also those related to his risk factors. You developed a goal specific to the priority problem. You did a nice job highlighting the related data, you could also consider highlighting his history of falls as well. Good job identifying the potential problems and the signs and symptoms that you would monitor the patient for. HS
	5. State the goal for the top nursing priority.	**Complete**			**Not complete**	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	7. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
	8. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	Great job developing nursing interventions that were specific the patient and the identified priority problem. You included a frequency and prioritized them, and included an appropriate rationale. HS
	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	11. All interventions include a frequency	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	12. All interventions are individualized and realistic	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	

Criteria		3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	3	You reassessed all of the abnormal findings in the evaluation of the top priority problem. HS
	15. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**	3	

Reference

An in-text citation and reference are required.
The care map will be graded "needs improvement" if missing either the in-text citation or reference, but not both.
The care map will be graded "unsatisfactory" if both in-text citation and reference are not included.

Total Possible Points= 45 points
45-35 points = Satisfactory
34-23 points = Needs Improvement*
< 23 points = Unsatisfactory*
***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

****Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. ****

Faculty/Teaching Assistant Comments:

Isabella,
Great job on your care map! You painted a very thorough picture of the plan of care for your patient. You identified all of the abnormal findings and developed appropriate interventions to implement. You then re-assessed the abnormal findings during the evaluation to determine that the plan of care should be continued. Great job! HS

Total Points:45/45

Faculty/Teaching Assistant Initials: HS

Firelands Regional Medical Center School of Nursing
Nursing Foundations 2024
Simulation Evaluations

Simulation Evaluation Performance Codes: **S**: Satisfactory **U**: Unsatisfactory	Simulation #1 (2,3,5,8) *	Simulation #2 (2,3,5,7,8) *
	Date: 11/5/2024	**Date: 11/25/2024**
Evaluation (See Simulation Rubric)	S	S
Faculty Initials	HS	HS
Remediation: Date/Evaluation/Initials	NA	NA

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

Student Roles: A=Assessment Nurse; M=Medication Nurse; O=Observer

STUDENT NAME(S) AND ROLE(S): Isabella Riedy (M), Yasmin Perez (O), Kyla Prenatt (A)
GROUP #: 5
SCENARIO: NF #1
OBSERVATION DATE/TIME(S): 11/5/2024 1430-1530

CLINICAL JUDGMENT COMPONENTS	**Observation Notes**
NOTICING: (1,2,4,6,7) *	**Focused observation**
• Focused Observation: E A D B	Focused observation on vital signs when entering the room.
• Recognizing Deviations from Expected Patterns: E A D B	Focused observation on patient's persistent cough and SOB.
• Information Seeking: E A D B	Focused observation on head-toe-assessment
	Focused assessment on patient's heels due to complaint of discomfort.
	Recognizing deviations from expected patterns
	Noticed BP 130/74, HR 82, RR 20, Spo2 91%, temp 99.2
	Noticed Spo2 of 91% on RA
	Noticed patient's persistent cough
	Noticed abnormal lung sounds.
	Did not notice tissues with sputum in patients' hand
	Did not notice reddened heels initially. When prompted by the patient of discomfort, focused assessment and noticed reddened heels.
	Information seeking
	Asked patients name and DOB when entering the room, remember to compare with the wrist band.
	sought additional information related to breathing status
	Sought information related to pain (0/10)
	Sought additional information related to patient's cough (duration, production, etc).

	Med nurse introduced self and role when entering the room. Sought information from the patient related to how she is feeling. Confirmed name and DOB with wristband prior to medication administration. Asked about patient allergies prior to medication administration. Sought information on normal bowel pattern Sought additional information related to elimination Asked patient how she takes her medications. Remember to ask about allergies prior to medication administration.
INTERPRETING: (1,2,4,6,7) * • Prioritizing Data: E A D B • Making Sense of Data: E A D B	**Prioritizing data** Prioritized vital sign assessment when entering the room. Prioritized oxygen administration immediately for low Spo2 Prioritized intervention for reddened heels Prioritized medication administration appropriately. **Making sense of data** Made sense of provider order for Spo2 to maintain greater than 93% Made sense of abnormal lung sounds related to pneumonia diagnosis Made sense of impaired skin integrity related to pressure Made sense of guaifenesin order Made sense of medications to be administered. Made sense of the MAR.
RESPONDING: (1,2,3,4,5,6,7) * • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B	**Calm, confident manner** Demonstrated confidence in nursing actions and communication with patient and team member. Answered patient's questions appropriately. Great teamwork and collaboration **Clear communication** Introduced self and role when entering the room.

	Good communication with the patient when entering the room Educated on the use of oxygen Communicated assessment and vital sign findings with the medication nurse. Educated patient on medications to be administered. Good education on medication side effects. **Well-planned intervention/flexibility** Consider elevating the HOB for cough and shortness of breath. Consider educating the patient to cough and deep breath. Applied O2 via nasal cannula for low Spo2. Returned to head to toe assessment after prioritizing oxygen status. Re-assessed Spo2 after oxygen administration and noticed improvement. Placed pillow to offload pressure. **Being skillful** Elevated HOB for safe medication administration. Good body mechanics raising the bed and lowering the side rail HEENT assessment performed accurately. Neuro assessment performed – remember to ask orientation questions to determine mental status. Heart and lung sounds auscultated accurately. ROM assessed in all extremities Pulses assessed and compared bilaterally. Strength assessed in all extremities, cap refill assessed GI assessment performed accurately (looked, listen, felt) GU assessment performed accurately. Assessed integumentary system. Remember to look at bony prominences (heels). Used BMV scanner for medication safety Observed the 7 rights of medication administration Performed the three safety checks.

REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	Observers did a great job actively paying attention to detail throughout scenario. Constructive feedback was provided during debriefing. Observers provided good insight on safe medication administration, including the rights of medication administration. Observers also praised students for initiating O2 via nasal cannula for low Spo2 per orders while also discussing the need for prompt intervention. Constructive feedback was provided related to areas for improvement. Good discussion and support amongst those performing in the scenario and the observers. Everyone participated well in debriefing. Each member of the team reflected on the experience and asked appropriate questions. Members of the team noticed areas for improvement and discussed ways to make improvements in the future. The assessment nurse and medication nurse demonstrated collaborative communication between the team members and the patient.
SUMMARY COMMENTS: * = Course Objectives **Satisfactory completion of the simulation scenario is a score of "Developing" or higher in all areas of the rubric.** **E= Exemplary** **A= Accomplished** **D= Developing** **B= Beginning** **Scenario Objectives:** • Demonstrate collaborative communication with patients and healthcare team members (1,3,8) * • Execute accurate and complete head to toe assessment (1,5,6,8) * • Select and administer prescribed oral medications following the six rights (1,4,5,7) * • Identify and provide accurate patient education (1,2,3,4,5,7) *	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Identifies obvious patterns and deviations, missing some important information. Actively seeks subjective information about the patient's situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. In most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse. Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Generally communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport. Develops interventions on the basis of the most obvious data; monitors progress but is unable to make adjustments as indicated by the patient's response. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses. **Satisfactory completion of NF Scenario #1.**

Lasater Clinical Judgment Rubric Scoring Sheet

Student Roles: A=Assessment Nurse; M=Medication Nurse; O=Observer

STUDENT NAME(S) AND ROLE(S): Yasmin Perez (A), Kyla Prenatt (M), Isabella Riedy (O)
GROUP #: 5
SCENARIO: NF #2
OBSERVATION DATE/TIME(S): 11/25/2024 1300-1400

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
NOTICING: (1,2,4,6,7) * • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B	Identified patient with name and DOB and compared to wristband for patient safety. Noticed low Spo2 (90%) when obtaining vital signs. Focused respiratory assessment. Noticed cough and shortness of breath. Noticed sputum/tissues in the bed. Sought further information related to duration of cough and sputum. Noticed crackles upon auscultation. Noticed patient was in pain. Focused pain assessment. Sought additional information related to pain (precipitating factors, relief measures, rating, location). Noticed patient's pain 7/10. Sought additional information by re-evaluating the patient's breathing status after oxygen administration. Noticed order for morphine and need to perform dosage calculation. Sought information related to allergies prior to medication administration. Consider asking patient preference for injection location. Sought additional information after medication administration related to relief and comfort.
INTERPRETING: (1,2,4,6,7) * • Prioritizing Data: E A D B • Making Sense of Data: E A D B	Prioritized vital signs when entering the room. Prioritized applying oxygen and made sense of physician orders to maintain Spo2 >93%. Prioritized focused respiratory assessment related to pain on the right side and shortness of breath. Prioritized focused pain assessment due to patient complaint.

	Prioritized pain medications prior to performing full assessment for patient comfort. Collaborated with medication nurse due to patient's complaints (discussed in debriefing). Made sense of the MAR related to pain rating and need for dosage calculation to be performed. Prioritized correct PRN pain medication (morphine for pain 7/10).
RESPONDING: (1,2,3,4,5,6,7) * • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B	Identified self and role when entering the room for communication. Applied oxygen via NC at 2L per physician orders due to low Spo2. Elevated HOB for shortness of breath. Performed pain assessment in response to patients' pain. Consider focusing your assessment on the location of pain (look, auscultate). Consider additional interventions for pain management (reposition, splinting, etc.). (discussed in debriefing). Dosage calculation performed accurately to determine need to waste 1ml (2mg) of morphine. Ordered 4mg (2ml), administered 4mg (2mL). Did not have witness for waste of excess narcotics (discussed in debriefing). Confirmed name and DOB prior to medication administration. Educated patient on morphine ordered for pain when prompted. Cleaned injection site using aseptic technique. Selected appropriately sized needle for IM injection (22g, 1inch). Remember to aspirate prior to injection. Good technique (90 degrees), pushed slowly. Good needle safety. Remembered the use of BMV after medication was administered (discussed in debriefing). Re-assessed pain after medication was administered to determine effectiveness. Consider re-assessing vital signs. Re-evaluated patient's breathing after applying oxygen. Good communication with the patient regarding plan for pain relief. Good communication among team members. Good communication with the patient during assessment for comfort. Re-evaluated Spo2 of 94% after oxygen administration and additional interventions, re-evaluated patient's breathing status after medication administration. Encouraged patient to utilize incentive spirometer. Education provided on appropriate use of incentive spirometer. Encouraged coughing and deep breathing after medication. Educated patient on use of splinting with a pillow when coughing (discussed in debriefing).

REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	Each member actively participated in debriefing. Each member of the team reflected on the experience and asked appropriate questions. Members of the team noticed areas for improvement related to prioritization and IM injections and discussed ways to make improvements in the future. Observers provided good insight on med safety and communication amongst team members and with the patient. Identified educational opportunities that were presented in the scenario. Reflected on clinical judgement and critical thinking that required. Emotions, thoughts and feelings were explored. Each member demonstrated a desire to improve nursing performance.
SUMMARY COMMENTS: * = Course Objectives **Satisfactory completion of the simulation scenario is a score of "Developing" or higher in all areas of the rubric.** **E= Exemplary** **A= Accomplished** **D= Developing** **B= Beginning** **Scenario Objectives:** • Demonstrate collaborative communication with patients and healthcare team members (1,3,8) * • Differentiate between need for complete head to toe versus focused assessment and execute accordingly (1,5,6,8) * • Select and administer prescribed oral and intramuscular medications following the six rights (1,4,5,7) * • Identify and provide accurate patient education (1,2,3,4,5,7) * • Recognize patient oxygenation and pain control needs and provide appropriate interventions (2,4,5,6,7) *	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes most obvious patterns and deviations in data and uses these to continually assess. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing and interacting with the patient and family. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. In most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse. Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Communicates effectively; explains interventions; calms and reassures patients and families; directs and involves team members, explaining and giving directions; checks for understanding. Interventions are tailored for the individual patient; monitors patient progress closely and is able to adjust treatment as indicated by patient response. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses. **Satisfactory Completion of NF Simulation #2!**

Nursing Foundations 2024
Skills Lab Competency Tool

Student Name: Isabella Riedy

Comments:

Skills Lab Competency Evaluation Performance Codes: **S**: Satisfactory **U**:Unsatisfactory		**Lab Skills**									
	Week 1 (4)*	**Week 2 (2,3,5,8)***	**Week 3 (2,3,4,5,8)***	**Week 4 (2,3,4,5,8)***	**Week 5 (2,3,4,5,8)***	**Week 6 (1,2,3,4,5,8)***	**Week 7 (2,3,4,5,8)***	**Week 8 (2,3,4,5,8)***	**Week 9 (2,3,4,5,8)***	**Week 10 (2,3,4,5,6,8)***	**Week 11 (2,5,7)***
	Date: 8/19/2024	**Date:** 8/28/2024	**Date: 9/5/24**	**Date:** 9/10/2024	**Date:** 9/17/2024 9/19/2024	**Date:** 9/24/2024	**Date: 10/1/204**	**Date:** 10/8,10/ 2024	**Date: 10/15/2024**	**Date:** 10/22/2024	**Date:** 10/29/2024
Evaluation:	S	S	S	S	S	S	S	S	S	S	S
Faculty Initials	HS	HS	NS	AR	BL	AR	NS	AR	FB	AR	AR
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

***Course Objectives**

Week 1 (Technology Lab): During this lab you were able to satisfactorily navigate:

- Edvance360 Learning Management System.
- Skyscape Resource System.
- Assessment Technologies Institute (ATI) / Virtual Simulation (vSim) Systems.
- Guided tour of library and computer lab. HS

Week 2 (Hand Hygiene; Vital Signs; PPE): During lab this week you were able to satisfactorily demonstrate:

- Appropriate hand hygiene utilizing hand sanitizer and soap/water.
- Accurate verbalization of procedure for donning & doffing PPE.

Appropriate level of skill during guided practice with measurement of radial and brachial pulses, along with manual blood pressure. Vital signs skills will be observed 1:1 with faculty during Week 3. Keep up the good work! HS

Week 3 (Vital Signs):

Awesome work in the lab this week! You satisfactorily completed the vital sign check off during 1:1 observation, including oral temperature, radial pulse, respiratory rate, pulse oximetry, and blood pressure measurement. During the blood pressure measurement, you accurately obtained two consecutive blood pressure results on the Vital Sim

manikin. The first blood pressure measurement was set at 134/78, and you identified it as 132/74, which was within the range for a satisfactory result. The second measurement was set at 156/92 and you interpreted it as 152/92, well within the desired range. You were able to verbally discuss the following measurements: axillary and rectal temperature along with orthostatic vital sign assessments. You did not require any prompts throughout the whole checkoff, great work! You provided accurate detail in your communication with the "patient". Your documentation was 100% accurate. Keep up the great work!! NS

Week 4 (Assessment):
Satisfactory with head to toe assessment guided practice, hand-off report activity, Lexicomp/Intranet navigation activity, and the assessment/safety activity utilizing your clinical judgment skills. Great job! You will be observed 1:1 for Head to Toe Assessment competency during Week 5. AR
Week 5 (Assessment; Mobility):
Excellent job in lab this week! You have satisfactorily performed a basic head to toe assessment in the skills lab. Your approach was systematic, thorough, and overall very well done. You paid close attention to detail and were well-prepared. You did not require any prompts throughout your assessment, nice work! You demonstrated professional and informative communication.
Feedback on documentation this week: With this being the first time that you fully documented these interventions, you did a great job paying close attention to detail! Overall you did a great job! Please review the physical reassessment and safety interventions within the next two weeks so you can examine areas that were inaccurate.

- Vital Signs- Documentation was accurate and complete.
- Physical reassessment- For the cardiovascular assessment (edema), omitted comment "toes to knee bil. and the entire left upper extremity."
- Safety- Omitted "pneumonia" as reason for isolation.
- Pain- Documentation was accurate and complete.

Mobility Lab 9/19/2024: Satisfactory completion of mobility lab through demonstration of the following: Logrolling/turning a patient, lifting a patient in bed, repositioning from lying to sitting, repositioning from sitting to standing, stand/pivot transfer from a bed to a chair, ambulating with a walker, ambulating with crutches, ambulating with a cane, use of a gait belt, and safe use of a wheelchair. Proper body mechanics were utilized to promote safety for the healthcare worker and the patient. Great job with active participation throughout the duration of the lab. BL
Week 6 (Personal Hygiene Skills):
Satisfactory with patient hygiene, making an occupied bed, shaving, oral care, hearing aid care, application of ace wraps, TED Hose/SCD's, and clinical readiness scenario during guided practice. Completed Meditech documentation for Hygiene and Ted Hose. Keep up the great work! AR
Week 7 (NG Skills: Insertion, Irrigation, and Removal; Feedings):
Nice job this week in the skills lab demonstrating competence for Nasogastric Tube Insertion, Irrigation, and Removal through 1:1 observation. You did not require any prompts throughout the entire process. It was evident that you were very well-prepared and went the extra mile to ensure you understood the entire process. Very impressive! You were able to verbalize understanding of the difference between irrigation and flushing and aspiration precautions. You were able to practice administering intermittent tube feeding using the gravity method while also confirming tube placement with gastric residual. Additionally, you participated in the PO intake station for accurate calculation of carbohydrate intake, accurately measured gastric output through the NG tube, practiced assisting a visually impaired patient with their meal, and completed the assigned documentation in Meditech. Keep up the hard work! NS
Week 8 (Foley Skills: Insertion, Removal; Sterile Gloves; I&O, Documentation Lab):
You did a great job in the lab this week and were satisfactory with the following skills: Sterile Glove Application, Foley Catheter Insertion (female), and Foley Catheter Removal. One prompt was needed during removal as a reminder to hold onto the catheter at the labia while the balloon is draining via gravity. You did not require any prompts during the sterile glove application or the insertion of the catheter. The balloon did malfunction by not emptying completely prior to removal, however you maintained completion of the procedure and acted professionally! You were thorough and had very good communication with your "patient". Great job! You correctly verbalized the differences in catheter insertion for a male patient. You actively participated in the Intake and Output stations, and completed Meditech documentation related to Urinary Catheter Management and Intake & Output. Keep up the great work!!! AR

Documentation Lab – You have satisfactorily completed the documentation lab by actively participating in Meditech documentation related to vital signs, physical re-assessment, safety and falls, pain assessment, patient rounds, TED hose/SCD/Ace wrap, feeding method, Intake and Output, urinary catheter management, and writing a nurse note. You utilized your time wisely, asked appropriate questions, and gained experience with each intervention listed in preparation for clinical. Great job! CB

Week 9 (Dressing Change: Dry Sterile, Damp to Dry Packed, Stoma Skills):

You have demonstrated competence in the skill of wound assessment and wound care through guided observation of Dry Sterile Dressing and 1:1 observation of Damp to Dry Packed Wound Dressing Change. During the Damp to Dry Packed Wound Dressing Change, you did not require any prompts and initiated/maintained the "clean" field and followed aseptic technique throughout. Your communication with the patient was excellent. Documentation was completed related to wound care and patient rounds in the Meditech system. Additionally, you participated in the stoma care station to gain additional knowledge and skills. Great job this week! FB

Week 10 (Safety; Infection Control; Prioritization; Weight; Pressure Ulcer Prevention; Soft Restraints; Doppler BP):

Satisfactory participation with the following stations: Prioritization, Patient Weight, Restraints, Doppler BP, Meditech documentation, and Patient Scenario involving Safety, Infection Control, and Pressure Ulcer Prevention. Keep up the hard work! AR

Week 11 (Medication Lab):

Satisfactory participation and performance of the following skills in the medication lab: Oral, IM, SQ, and ID medication administration; performance of IM injection on fellow student; performance of SQ & ID injection on practice sponge; use of and drawing medication out of ampule and vial; communication/accountability activity with awareness of allergies & dosage calculation. AR

EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

I was given the opportunity to review my final clinical ratings in each course competency. I was given the opportunity to ask questions about my clinical performance. I have the following comments to make about my clinical performance/final clinical evaluation:

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Student eSignature & Date: ___Isabella Riedy_____12/02/2024_____